CHAPTER

5

ICF/MR LEVEL OF CARE

In order to be enrolled in the MR/RD Waiver, the applicant must have mental retardation or a related disability as determined by SCDDSN, be eligible to receive Medicaid, be allocated a waiver slot, choose to receive services in his/her home and community and meet ICF/MR Level of Care (the applicant does not have to be currently served by SCDDSN).

Initial ICF/MR Level of Care Evaluations for the Purpose of Enrolling in the MR/RD Waiver

The Consumer Assessment Team makes the initial determination of ICF/MR Level of Care. Once a slot had been allocated, feasible alternatives under the Waiver have been explained to the applicant, and he/she has been given a choice of institutional services or home and community-based services, you must request a determination of Level of Care.

The initial determination is requested by completing the **Request for MR/RD Level of Care (MR/RD Form 9)** and forwarding records that support this Level of Care to the Consumer Assessment Team (8301 Farrow Road; Columbia, SC 29203-3294). The information to be sent **must** include:

1. Formal psychological evaluation(s) that includes cognitive and adaptive scores that support a diagnosis of mental retardation or a related disability. Every effort should be made to locate the report that is noted on the applicant's Eligibility Letter as well as any additional, current evaluation reports, if applicable.

   If the applicant does not have mental retardation and/or is served in another eligibility category (i.e. related disability), appropriate supportive documentation is required. This may not be a psychological evaluation, but may be, for example, a report from the SCDDSN Autism Division, or appropriate medical, genetic or adaptive assessments. The SCDDSN Eligibility letter should always be included for those who have a related disability. If the Eligibility Letter cannot be located, a print-out of the SCDDSN STS eligibility menu will suffice.

2. Current Support Plan, Indualized Family Service Plan or Family Service Plan.

3. Any/all other current (within one year) signed and dated information pertaining to:

- Daily living and other adaptive functioning
- Behavior/emotional functioning; and/or
- Medical and related health needs.

If a Behavior Support Plan (BSP) is referenced in the applicant's current Plan, every effort should be made to include a current, signed and dated BSP in your packet.

If the applicant is a child receiving EI through BabyNet (i.e., not DDSN eligible), or is served by DDSN as a High-Risk Infant or At-Risk Child the following support documentation should be included in your packet:

- A SCDDSN Eligibility Letter (if applicable).
- A current (within 3 months) screening assessment (this may include the HELP, ELAP, Carolina Curriculum, *etc*.).
- All available relevant medical, genetic and developmental reports. (This may include historical as well as current information).

If the applicant is served through the Head and Spinal Cord Injury (HASCI) Division, all current/prior school records including transcripts, IEPS, and psychological reports should be included with the request for Level of Care.

After file review, the Consumer Assessment Team may return the request to the Service Coordinator or Early Interventionist with a communication exchange and request that the applicant be tested by a SCDDSN approved psychologist. The Consumer Assessment Team may also request additional records or reports prior to completing the evaluation.

If a MR/RD Waiver slot has been allocated, and the Level of Care Determination is requested at the same time as a request for a determination of eligibility for services, the eligibility decision will be completed first. In this case, duplicate packets should be sent to the Consumer Assessment Team, with corresponding coversheets for eligibility and Level of Care.

Please note: The SCDDSN Consumer Assessment Team has the discretion to request that an applicant's current eligibility be reevaluated prior to completion of a Level of Care Determination request if, after file review, there is a question as to the appropriateness of the applicant's current eligibility category.

Once all needed information is received, the Consumer Assessment Team will review the information and complete all sections of the Level of Care Determination for ICF/MR form. **To be valid, all items on the form must be completed**. The Consumer Assessment Team should render a decision regarding Level of Care within ten (10) days of receipt of the **MR/RD Form 9** and the needed information.

When the Level of Care determination has been made, the Consumer Assessment Team will certify that the applicant does or does not meet ICF/MR Level of Care. This is done by completing the **SCDDSN Level of Care Certification Letter** and mailing the completed letter, with the procedure for appeals printed on the reverse side, to the applicant and a copy to the Service Coordinator/Early Interventionist. The Consumer Assessment Team is also responsible for providing the SCDDSN Waiver Coordinator with the Level of Care information needed for enrollment. In addition to the Certification Letter, you will receive additional forms (e.g., **Level of Care Determination for ICF/MR and Level of Care Staffing Report - MR/RD Form 7**) that have been used by the Consumer Assessment Team to determine whether or not ICF/MR Level of Care was met. These forms along with the Certification Letter should be kept in the applicant's file (this information should always remain in the file and NEVER be purged).

Applicants Who Do Not Get Enrolled within 30 days of the Initial Level of Care Determination:

Waiver Enrollment must occur within thirty (30) days of the Level of Care Determination date. (Please see "Enrollments" for more specific information). If the applicant's Level of Care Certification was effective 30 days or more prior to waiver enrollment, a new SCDDSN Certification Letter must be issued. If a Waiver applicant's Level of Care has expired prior to enrollment in the MR/RD Waiver, **a recertification does not have to be done immediately.** As long as enrollment occurs within 180 days of the initial Level of Care, it may be recertified/updated once all enrollment issues have been resolved (Please note if more than 180 days has passed since completion of the initial Level of Care Determination, then a new initial Level of Care Determination is required). Please utilize the following steps for MR/RD Level of Care recertification:

1. Immediately contact the Waiver Enrollments Coordinator when you note that a Level of Care is about to expire or has already exceeded thirty days. **Please note, if the Waiver Enrollments Coordinator has completed all paperwork regarding the enrollment and the request has been submitted to DHHS, there is no need to re-certify the Level of Care. This may be determined by checking the enrollment status on the Waiver Tracking system under ENINS. If the enrollment status indicates "awaiting" then the request has already been submitted to DHHS and re-certification is not required.**

2. The Waiver Enrollments Coordinator will verify if all enrollment information is completed. If so, you may request recertification of the Level of Care. If the case is not ready for enrollment, the Waiver Enrollments Coordinator will contact you when the Level of Care needs to be recertified/updated.

3. Prior to requesting the recertification from the Consumer Assessment Team, you must contact the applicant **to verify that the applicant's condition has not changed since completion of the Initial Level of Care Determination.** This process is completed to be completed as follows:

    a. Review the Level of Care Determination Form and the supporting documentation upon which the initial Level of Care was initially completed.

    b. Determine if the record contains more current reports or other information that might impact the answer to each specific question on the Level of Care Determination Form.

    c. Contact the applicant to determine if his/her status has changed to the extent that it would change the Level of Care decision. **The results must be clearly documented in the applicant's file and in a notation to the Consumer Assessment Team.**

If the applicant's status **has not changed**, please contact the Consumer Assessment Team via telephone and request a Level of Care recertification/update. You must resubmit via fax, a **new MR/RD Form 9 (indicate on the form that it is an initial LOC (expired) and enrollment did not occur with 30 days of the LOC effective date)**, the initial **Level of Care Determination for ICF/MR** form and the **Certification Letter** along with a request for issuance of a new Certification Letter. You must also include on the fax cover sheet that the applicant's condition has not changed and with whom you verified that information, so that the Consumer Assessment Team may complete the recertification/update. You must verify that the applicant is ready for enrollment by consulting with the Waiver Enrollments Coordinator (Attachment 1 in Chapter 6) prior to contacting the Consumer Assessment Team. The Waiver Enrollments Coordinator will notify the Consumer Assessment Team via e-mail that the applicant is ready for enrollment into the MR/RD Waiver once all of the enrolment issues are resolved.

Once the recertification is completed by the Consumer Assessment Team, you will receive a new Certification Letter along with the updated Level of Care Determination for ICF/MR Form. When the initial Level of Care is updated, the date of the update becomes the **new effective date** of the Level of Care. To document that the initial Level of Care was updated, the Director of the Consumer Assessment Team will sign, date and notate "update" on the initial Level of Care Determination form below the signature line and a new Level of Care Certification Letter will be completed. The Consumer Assessment Team will notify the Waiver Enrollments Coordinator of the new Level of Care date.

Once the Level of Care has been recertified, it CANNOT be recertified again. If the applicant is not enrolled in the MR/RD Waiver within thirty (30) days of the recertification, then a new Level of Care packet must be submitted to the Consumer Assessment Team.

If the applicant's status **has changed**, a new initial Level of Care packet must be submitted to the Consumer Assessment Team. The team should be apprised via telephone as to why this Level of Care is being requested. The Service Coordinator or Early Interventionist should determine what current reports or other information is needed that might impact the answer to each specific questions on the Level of Care Determination Form, obtain these records and add them to the original packet that was submitted to the Consumer Assessment Team. A New MR/RD Form 9 must be completed.

Please Note: the Consumer Assessment Team has the discretion to deny a recertification and ask that a new initial Level of Care packet be submitted.

ICF/MR Level of Care Reevaluations/Redeterminations for MR/RD Waiver Recipients:

Once enrolled, ICF/MR Level of Care evaluations are valid for up to one year (365 days) unless otherwise stipulated by the Consumer Assessment Team, but can never be more than 365 days. Each recipient must be evaluated at least annually (or as needed given changes in condition, diagnosis, etc.) and certified to meet ICF/MR Level of Care in order to continue to receive services funded through the MR/RD Waiver. The Service Coordinator/Early Interventionist will be responsible for these annual re-evaluations and certifications except for those recipients who are eligible on a time-limited basis. For those who are served in a time-limited basis under the eligibility categories of Mental Retardation, Related Disability, At-Risk Child, or High-Risk Infant, the Level of Care re-evaluation must be completed by the Consumer Assessment Team. The same information required for an initial Level of Care evaluation plus the most recent Level of Care Determination for ICF/MR and Certification Letter must be sent to the Consumer Assessment Team

For all other recipients, the Service Coordinator/Early Interventionist is responsible for the annual re-evaluation of ICF/MR Level of Care. These re-evaluations must be conducted within three hundred sixty-five (365) days of the previous Level of Care Determination/Assessment date. The review will, **at a minimum**, consist of a review of the most recent psychological, social and medical information along with a review of the current IFSP/FSP, Single Plan, and/or IEP. Based on the review of the information, you must complete the **Level of Care Determination for ICF/MR**.

Please Note: All items on the determination form must be scored/completed. Failure to score/complete all items will render the determination invalid. No waiver services can be authorized in the absence of a complete and valid LOC Determination.

Based on the results of the re-evaluation, you must certify that the recipient does or does not continue to meet ICF/MR Level of Care. This certification is given by completing the **SCDDSN Level of Care Certification Letter**. When completing, enter the date of the certification, which is the date on which the determination was completed, and the expiration date, which will, in most cases, be one year from the effective date (EXAMPLE: Effective: 9/12/98, Expires: 9/11/99). You may certify a recipient to meet Level of Care for less than one year if his/her condition warrants a more frequent review. If this option is chosen, you must document the reason for the shorter certification period in the recipient's record.

All decisions must be reviewed by your Supervisor or the Executive Director of your DSN Board/Provider. All Level of Care re-evaluations must be documented along with the review from the Supervisor or Executive Director. Once the supervisory review is complete if determined to meet ICF/MR LOC, the Level of Care Certification Letter along with the Level of Care Determination for ICF/MR should be placed in the recipient's file

Also, **if the recipient is found to meet ICF/MR Level of Care,** you must enter the effective date of the certification onto the Waiver Tracking System. This should be done within one (1)

working day of the determination. To do so, enter the Waiver Tracking System, select the "enrollment menu" (ENMEN), then select "Update Last Loc Reeval Date" (ENLDT) and enter the recipient's name or ID number. Next, enter the effective date of the reevaluation certification (See your Supervisor to determine your agency's procedure for Level of Care updates).

If the recipient is found to <u>not</u> meet ICF/MR Level of Care, all information used to make this determination along with the completed Level of Care Determination for ICF/MR and the Certification Letter must be submitted to the Consumer Assessment Team. An **MR/RD Form 9** (indicate "found to not meet ICF/MR LOC by DSN Board/Provider" on form) requesting a review of the decision should also be sent. The Consumer Assessment Team must complete the review of the determination prior to the expiration date of the current certification. If the Consumer Assessment Team concurs with the determination that the recipient does not meet ICF/MR Level of Care, the Consumer Assessment Team Director will co-sign the Level of Care Determination for ICF/MR and the **SCDDSN Level of Care Certification Letter** and mail the **SCDDSN Level of Care Certification Letter**, with the procedure for appeals printed on the reverse side, to the recipient and a copy to the Service Coordinator/Early Interventionist. You must keep all documentation regarding this decision in the recipient's file. Please note that if a recipient no longer meets ICF/MR Level of Care, then he/she can no longer participate in the MR/RD Waiver. Therefore, you would initiate procedures for disenrollment (See Chapter 6 for instructions).

If the recipient is found to not meet ICF/MR Level of Care, and the Consumer Assessment Team **<u>does not concur</u>** with the decision, the decision will be overruled. The Consumer Assessment Team will signify their disagreement with the decision by completing a new **Level of Care Determination for ICF/MR** and **SCDDSN Level of Care Certification Letter** and returning it to the Service Coordinator/Early Interventionist. You must keep all documentation of this decision in the recipient's file.

<u>Please Note:</u> If for some reason a recipient is found to no longer have Mental Retardation or Related Disability, the Service Coordinator/Early Interventionist must re-evaluate if the recipient continues to meet LOC warranted anytime a recipient's condition changes. Without having MR or RD the applicant would not meet Level of Care. Once found to not meet LOC, the process for review by the Consumer Assessment Team previously described in this chapter must be followed.

South Carolina Department of Disabilities and Special Needs
Consumer Assessment Team
Request for ICF/MR Level of Care (MR/RD Waiver)

Date: _____

Consumer: _____

Consumer's Address: _____

_____

County of Residence: _____

Medicaid #: | | | | | | | | | | |

SSN#: | | | | | | | | | |

Board/Provider: _____

Dist. Office Rep/QMRP: _____
(for ICF/MR consumers)
SC/EI and phone #: _____
SC/EI E-mail address: _____

LOC Request

☐ Initial LOC (First time sent to CAT)
☐ Initial LOC (Consumer Disenrolled/Seeking to re-enter the MR/RD Waiver)
☐ Initial LOC (expired)
  ☐ Enrollment did not occur within 30 days of LOC effective date
  OR
  ☐ Over 365 days old
  Copy of last LOC dated_____ (Included with packet)

☐ Annual Re-evaluation for time limited eligibility only
  Waiver Enrollment date:_____
  Time Limited eligibility expiration date:_____
  Copy of last LOC dated_____ (Included with packet)

☐ Found to not meet ICF/MR LOC by the DSN Board/Provider

Eligibility Category

☐ Mental Retardation
☐ Related Disability_____ Specify
☐ High Risk Infant/At Risk Child
☐ Spinal Cord Injury
☐ Head Injury
☐ Similar Disability_____ Specify

Waiver Enrollment Information (for MR/RD only)

Has this person been institutionalized? ☐Yes ☐No

Did this person begin waiver services immediately following move from ICF/MR? ☐Yes ☐No

Date Freedom of Choice (MR/RD Form 1) signed: _____

TO BE COMPLETED BY CAT LOCATED AT THE MIDLANDS FIELD OFFICE

Level of Care Effective Date:_____ ☐ **Found to not meet ICF/MR Level of Care**

_____ _____

SC, EI, QMRP, or District Office Rep **Service Coordinator/Early Intervention Supervisor**

MR/RD Form 9 (1/05)

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

LEVEL OF CARE

CERTIFICATION LETTER

TO: _____ COUNTY OF RESIDENCE _____

SS#: _____ MEDICAID # _____

LOCATION OF ASSESSMENT: _____

The South Carolina Department of Disabilities and Special Needs has evaluated the information submitted by your physician and other professionals and has determined that:

( ) according to Medicaid criteria, you do not meet medical requirements for Intermediate Care for the Mentally retarded. This does not mean that you do not need personal or other medical care, and does not mean that you cannot be admitted to a long-term care facility. It does mean that the Medicaid program will not be responsible to pay for your care in a long-term care facility.

( ) according to present Medicaid criteria, you meet requirements to receive long term care at the following level:

( ) Intermediate Care Level for the Mentally Retarded

This letter must be presented to the facility to which you are admitted.

This certification letter is not an approval for financial eligibility for Medicaid. You must establish financial eligibility with the County Department of Social Services.

If you disagree with this determination, please read the reverse side of this notification.

EFFECTIVE DATE: _____ EXPIRATION DATE _____

_____

SIGNATURE/TITLE

_____

DATE OF ASSESSMENT

(10/04)

SCDDSN RECONSIDERATION PROCESS AND SCDHHS MEDICAID APPEALS PROCESS

The SC Department of Disabilities and Special Needs (SCDDSN) is responsible for the day-to-day operations of the Mental Retardation/Related Disabilities (MR/RD) Waiver and the Head and Spinal Cord Injury (HASCI) Waiver. A request for reconsideration of an adverse decision **must be** sent in writing to the State Director at SCDDSN, P. O. Box 4706, Columbia, SC 29240. The SCDDSN reconsideration process **must be** completed in its entirety before seeking an appeal from the South Carolina Department of Health and Human Services (SCDHHS).

A formal request for a reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. The request must state the basis of the complaint, previous efforts to resolve the complaint and the relief sought. The reconsideration request must be dated and signed by the consumer, representative, or person assisting the consumer in filing the request. If necessary, staff will assist the consumer in filing a written reconsideration.

Note: In order for waiver benefits/services to continue during the reconsideration/appeal process, the consumer/representative's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision. If the adverse action is upheld, the consumer/representative may be required to repay waiver benefits received during the reconsideration/appeal process.

The State Director or his designee shall issue a written decision within ten (10) working days of receipt of the written reconsideration request and shall communicate this decision to the consumer/representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written decision.

If the consumer/representative fully completes the above reconsideration process and is dissatisfied with the results, the consumer/representative has the right to request an appeal with the SCDHHS. The purpose of an administrative appeal is to prove error in fact or law. The consumer/representative must submit a written request to the following address no later than thirty (30) calendar days from the receipt of the SCDDSN written reconsideration decision.

Division of Appeals and Hearings
SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

The consumer/representative must attach copy of the written reconsideration notifications received from the SCDDSN regarding the specific matter on appeal. In the appeal request the consumer/representative must clearly state with specificity, which issue(s) the consumer/representative wishes to appeal.

Unless the request is made to the above address within thirty (30) calendar days of the receipt of the SCDDSN written reconsideration decision, the SCDDSN decision will be final and binding. An appeal request is considered filed at the above address if postmarked by the thirtieth (30^{th}) calendar day following receipt of the SCDDSN written reconsideration decision. The consumer/representative shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request.

LEVEL OF CARE DETERMINATION FOR ICF/MR

NAME _____ **ID** _____ **DOB** _____

1. Person has: (at least one of the following)

   a) MR: _____Yes _____No

   b) Related Disabilities: _____Yes _____No

Based upon the following assessment(s), copies of which may be found in the client record:

_____ _____
Date

AND

2. Supervision is necessary due to: (at least one of the following)

   Impaired judgment/limited capabilities _____ Yes _____ No

   Behavior problems _____ Yes _____ No

   Abusiveness _____ Yes _____ No

   Assaultiveness _____ Yes _____ No

   Drug effects/medical monitorship _____ Yes _____No

Based upon the following assessment(s), copies of which may be found in the client record:

_____ _____
Date

AND

3. Services are needed for: (at least one of the following)

   a) acquisition of behaviors necessary to function with as much self determination and independence as possible _____ Yes _____ No

   b) prevention or deceleration of regression or loss of current optimal functional status. _____ Yes _____ No

Based upon the following assessment(s), copies of which may be found in the client record:

_____ _____
Date

APPROVED FOR ICF/MR LEVEL OF CARE _____ Yes _____ No

_____Initial Determination _____Annual Recertification _____Other (specify)

_____ _____
Signature/Title Date

MR/RD (revised 9/02)

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
LEVEL OF CARE EVALUATION

STAFFING REPORT

Individual's Name: _____

Social Security #: | | | | | | | | | |

The above named individual has been determined by the Office of Consumer Assessment to

☐ meet ☐ not meet

the Medicaid Level of Care criteria for ICF/MR.

Team Member Signatures:

_____

_____

_____

_____

_____

Physician Signature and Date:

_____

Evaluation Date: _____

MR/RD Form 7 (8/99)